(1)
Supreme Court, U.S.
FILED
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No. _____

# In the Supreme Court of the United States

DONNA J. FARFALLA,

*Petitioner*,

v.

MUTUAL OF OMAHA INSURANCE COMPANY,

*Respondent*.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

## PETITION FOR WRIT OF CERTIORARI

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## QUESTION PRESENTED FOR REVIEW

Under this Court's holding in *Firestone Tire and Rubber v. Buch*, 489 U.S. 101, 103 L.Ed.2d. 80, 109 S.Ct. 948 (1989), was the Trial Court's criteria for determining the presence of a conflict of interest with regard to the Plan Administrator and Fiduciary for a policy of disability insurance governed by Employee Retirement Income Security Act, 29 U.S.C. 1101, et seq. (hereinafter "ERISA"), and method in determining the applicable standard of review correct, particularly when compared to other circuits methods and criteria when dealing with the same issues?

## PARTIES TO THE PROCEEDINGS

The caption of this Petition fully identifies all parties to this appeal.

## TABLE OF CONTENTS


Page

QUESTION PRESENTED FOR REVIEW . . . . . i

PARTIES TO THE PROCEEDINGS . . . . . ii

TABLE OF CONTENTS . . . . . iii

TABLE OF AUTHORITIES CITED . . . . . v

OPINIONS BELOW . . . . . 1

JURISDICTION . . . . . 1

STATUTES AND RULES INVOLVED . . . . . 1

STATEMENT OF THE CASE . . . . . 3

Basis for Federal Jurisdiction . . . . . 6

The Trial . . . . . 6

The Judgment of the District Court . . . . . 8

The Appeal . . . . . 8

REASONS FOR GRANTING THE WRIT . . . . . 9

CONCLUSION . . . . . 15

APPENDIX

**Appendix A**
Opinion of the United States Court of Appeals
for the Eighth Circuit.
Dated April 3, 2003 . . . . . 1a

**Appendix B**
District Court Memorandum and Order.
Dated May 21, 2002 . . . . . 7a

**Appendix C**
Excerpts of Trial Testimony . . . . . 17a

## TABLE OF AUTHORITIES CITED

**Cases:** Page

*Armstrong v. Etna Life Insurance Company*,
128 F.3d. 1263 (8th Cir. 1997) . . . . . 14

*Atwood v. Newmont Gold Co., Inc.*,
45 F.3d 1317 (1995 U.S. App.) . . . . . 11-13

*Brown v. Blue Cross & Blue Shield of Alabama, Inc.*,
898 F.2d 1556 (11th Cir. 1990)
(footnote omitted), cert. denied,
498 U.S. 1040, 112 L.Ed. 2d 701,
111 S.Ct. 712 (1991) . . . . . 11, 12

*Doe v. Group Hospitalization & Medical Serv.*,
3 F.3d 80 (4th Cir. 1993) . . . . . 11, 12

*Firestone Tire and Rubber v. Buch*,
489 U.S. 101 L.Ed.2d. 80,
109 S.Ct. 948 (1989) . . . . . i, 12, 13

*Schatz v. Mutual of Omaha Insurance Company*,
Mutual of Omaha, Appellee,
220 F.3d. 944 (2000) . . . . . 9-10

*Sullivan v. LTV Aerospace and Defense Co.*,
82 F.3d 1251 (1996 U.S. App.) . . . . . 13

*Van Boxel v. Journal Co. Employees' Pension Trust*,
836 F.2d 1048 (7th Cir. 1987) . . . . . 11, 12

*Weinberger v. Reliance Standard Life Insurance Company*, 54 Fed. Appx. 553; (2002, U.S. App.) . . . . . 10

*Woo v. Hartford Life Insurance Company*, 144 F.3d. 1157 (1998) . . . . . 9, 10

**Statutes:**

28 U.S.C. § 1254(1) . . . . . 1

29 U.S.C. § 1001 . . . . . 14

29 U.S.C. § 1101 . . . . . i, 5, 6

29 U.S.C. § 1101(a) . . . . . 1

29 U.S.C. § 1101-1461 . . . . . 1

The Petitioner, Donna Farfalla, respectfully prays that a Writ of Certiorari be issued to review the judgment of the United States Court of Appeals of the Eighth Circuit affirming the Order of the United States District Court of the District of Nebraska dismissing the Petitioner's Petition.

## OPINIONS BELOW

On April 3, 2003 the Eighth Circuit affirmed the dismissal of Petitioner's claim under the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1101-1461. A copy of the opinion is included herein as "Appendix A". The decision is reported at 324 F.3d 971; 2003.

The decision appealed to the Circuit Court is the Memorandum and Order filed on May 21, 2002, by the Honorable Joseph F. Bataillon, District Judge, District of Nebraska. A copy of the Memorandum and Order is included herein as "Appendix B". That decision is not reported.

## JURISDICTION

The opinion of the United States Court of Appeals for the Eighth Circuit was issued on April 3, 2003. Accordingly, this Court has jurisdiction under 28 U.S.C. § 1254(1).

## STATUTES AND RULES INVOLVED

29 U.S.C.S. 1101 (a) provides:

> Benefit plans as affecting interstate commerce and the Federal taxing power. The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the

operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and

> stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

## STATEMENT OF THE CASE

On February 1, 1995, Respondent received Petitioner's claim for long term disability benefits based upon a disability that began on December 31, 1994, initially for a left distal radius fracture. Prior to the final denial of Petitioner's claim, Respondent was aware of the following medical conditions that Petitioner suffered from: a broken right wrist, numbness in her hands, small lump in her upper back, left radial fracture and bilateral carpal tunnel. Petitioner had been employed at Creighton University as a Cardiac Monitor Technician between 1990 and 1996. A Cardiac Monitor Technician requires repetitive typing quickly. Keyboarding was considered an essential function of her job and was frequently required.

Dr. Tiedeman, stated that Petitioner became disabled on December 31, 1994 and "is totally disabled from her job and any other work." On November 9, 1995, a functional capacity determination was performed at Our Lady of Lourdes, which revealed that she had limited use or tolerance

for hand activity. On January 25, 1996, Dr. Tiedeman also reported that "a job site visit with subsequent recommendations from a therapist would probably be helpful." In August 1996, Petitioner underwent surgery for carpal tunnel syndrome. On September 26, 1996, Petitioner was released back to work with restricted activities of data entry no more than fifty (50) percent of the time. On December 9, 1996, Mae Ommen, requested forty-five days of job placement for Petitioner. Benefits were thereby allowed to January 30, 1997, since she was involved in job placement.

Petitioner applied for Social Security benefits initially in January 1997, when she learned that she was getting her last check from Respondent. The decision to apply for social security benefits was based upon Respondent's suggestion to do so. The Social Security Award determined that in addition to her bilateral carpal tunnel and left ulna radius and styliod fractures, she also had fibromyalgia.

Another Functional Capacity Evaluation was performed on June 17, 1997 at Faith Regional Center (after termination of benefits by Respondent) which showed that Petitioner should engage in no more than thirty (30) minutes duration of use of her hands or upper extremities. "It may be difficult to place Ms. Farfalla in a work environment without interventions such as job site analysis, vocational counseling or further training or more education." Further, "I would recommend that Ms. Farfalla return to activities at or below the level indicated in this assessment."

As of October 20, 1997, Respondent was aware that Petitioner had filed for Social Security benefits, and was initially rejected. The initial Social Security determination was made on March 3, 1997. A peer review request was made by Mutual of Omaha on November 26, 1997, after Petitioner had

made her initial request for Social Security Disability benefits, but before they were actually granted. A final report by Dr. Nudelman, the peer review, was issued on December 18, 1997.

After having been awarded Social Security Disability benefits, Petitioner submitted her social security disability decision to Respondent. However, Respondent again declined to reconsider its decision.

Final denial by Respondent was made on December 30, 1997. Petitioner's Complaint was filed on December 21, 2000. In that Complaint, Petitioner alleged that Petitioner was insured under a policy of disability insurance issued by Respondent, pursuant to Employee Retirement Income Security Act (hereinafter "ERISA"), 29 U.S.C. § 1101, et seq. Petitioner made claim under the terms of that policy, but Respondent refused to pay benefits, and through the administrative appeals process, Respondent's final denial was made on December 30, 1997. Petitioner further alleged a breach of fiduciary duty and an erroneous decision made by Respondent. Respondent filed its Amended Answer on February 22, 2001. Respondent, in its Answer, admits that Petitioner complied with the terms of the administrative appeal process and that Respondent was a fiduciary under the terms of the policy.

The policy itself defined disability as "your inability to work because of an injury or sickness. During your first twenty-four months disability you are totally disabled only if: (a) you cannot perform most of the main functions of your job; and (b) you are not paid for performing any other job." After twenty-four months, the definition of disability changed to "if you can not work for pay at any job for which you are reasonably fitted by education, training, or experience."

Respondent paid disability benefits to Petitioner from January 30, 1995 to January 30, 1997. That policy also provided that there would be a reduction in benefits by indemnity payments that claimant or her beneficiaries were eligible to receive due to Social Security.

The policy itself, provided in relevant part that "if, while insured under this provision, you become totally disabled, we will pay the monthly income benefits shown in the schedule." Respondent admits in its Amended Answer that it has been granted the discretion and final authority to construe and interpret the policy, and that it is a fiduciary under the terms of the policy.

## BASIS FOR FEDERAL JURISDICTION

Ms. Farfalla pursued her claim for benefits under Employee Retirement Income Security Act, 29 U.S.C. § 1101, et seq. by pursuing all administrative appeals and performing all conditions precedent, before filing suit in the United District Court for the District of Nebraska on December 21, 2000.

The District Court below founded its jurisdiction upon the Employee Retirement Income Security Act, 29 U.S.C. § 1101, et seq.

## THE TRIAL

During the trial of this matter on January 3, 2002, the manager of group disability claims at the time of the claim, Gary Suing, testified. Mr. Suing testified that Respondent is the claims administrator for this policy, decides what claims to pay and not pay, and was a fiduciary. Mr. Suing also admits that under the terms of the policy, Respondent had a

duty to act in the interest of the claimant. Claims made under the policy were to be paid out of Respondent monies. Under the terms of the policy, Respondent was to pay both disability and pension benefits to Petitioner. When asked if Respondent had a financial incentive under the terms of the policy, Gary Suing admitted that Respondent saved money by not having to pay disability payments to Petitioner. In his words, "Mutual had a financial interest which was affected by whether or not to continue paying disability payments to Claimant." That policy also provided that there would be a reduction in benefits by indemnity payments that claimant or her beneficiaries were eligible to receive due to Social Security. This was also admitted to by Gary Suing.

Gary Suing admitted that it was "common practice" for Respondent to encourage claimants to apply for Social Security disability. Suing acknowledged that the policy provided for an offset to the long-term disability policy for any social security benefits received, and this was a financial advantage to Respondent. Suing was also aware of the Social Security rules and regulations and was aware that the Social Security definition of disability was similar to Respondent's. Respondent was aware that Petitioner eventually qualified for Social Security disability.

Gary Suing admitted at trial that Respondent regularly sends five (5) to ten (10) cases per year to Dr. Nudelman, a peer review company, of which Petitioner was one case. However, Dr. Nudelman never examined Petitioner; and never actually talked to her. Respondent never hired an orthopedist to examine her records for bilateral carpal tunnel or her fractures. Respondent never had her examined by an independent medical examiner. This was in spite of the fact that Respondent's own peer review physician, Dr. Nudelman, was of the opinion that there may be some psycho-social

factors to yet be considered with respect to Petitioner's employability.

Evidence was produced, and the Trial Court found, that although Petitioner attempted to find substitute employment on numerous occasions, she was unsuccessful.

## THE JUDGMENT OF THE DISTRICT COURT

In its opinion, issued May 21, 2002, the District Court determined that review of the administrator's decision should be for abuse of discretion and refused to apply the less deferential "sliding scale" standard of review. In reaching that decision, the District Court determined that the Petitioner had not presented sufficient evidence to warrant application of the less deferential review. The District Court found in applying the abuse of discretion standard that "the reviewing court is limited to a review of the evidence that was before the Plan Administrator when the final decision was made." and that based upon that information, the Respondent's decision was not clearly unreasonable.

## THE APPEAL

Following the Judgment of the District Court, Ms. Farfalla timely filed her Notice of Appeal to the United States Court of Appeals for the Eighth Circuit. In written argument to that Court, Ms. Farfalla complained that the District Court had erred in its dismissal of her ERISA case.

The Circuit Court affirmed the District Court's grant of judgment as a matter of law in a published opinion.

## REASONS FOR GRANTING THE WRIT

There is a substantial conflict among the circuits in determining the applicable standard of review for cases filed under ERISA in which the Plan Administrator labors under a conflict of interest. In this case, the Circuit Court found that the Petitioner had failed to sufficiently prove that the Plan Administrator's decision was affected by the conflict of interest and therefore, decided the matter an abuse of discretion standard of review. The various circuits have wide ranging criteria for a sufficient showing of a conflict of interest, and additionally, once their individual standard for a showing of conflict of interest on the plan administrator's part is satisfied, the proper standard of review for the claim.

In many circuits, such as the Sixth and the Eighth, the general rule in determining the standard of review to apply in these types of cases is that in order to obtain a less deferential standard of review than the abuse of discretion standard, a plan participant must present material evidence demonstrating 1) that a palpable conflict of interest or a serious procedural irregularity existed that caused 2) a serious breach of fiduciary duty to her. *Woo v. Hartford Life Insurance Company*, 144 F.3d. 1157 (1998). The first part of the gateway test as described in *Woo*, is satisfied when a for-profit insurer is also the Plan Administrator, as in the case at hand. In order to satisfy the second requirement, the plan participant must only show that the conflict or procedural irregularity has some connection to the substantive decision reached. *Id.*

When the insurer is also the Plan Administrator, many circuit courts also recognize something akin to a rebuttable presumption of a palpable conflict of interest. *Schatz v. Mutual of Omaha Insurance Company, Mutual of Omaha,*

Appellee, 220 F.3d. 944 (2000). In the case at hand, there was a palpable conflict of interest in that the Plan Administrator was also the fiduciary and had a financial incentive to shift the cost of disability to taxpayers by placing them on social security disability benefits. The fact that Petitioner did not receive Social Security Disability benefits until after termination of her ERISA benefits is irrelevant given that the financial offset occurs when the recipient qualifies for Social Security Disability, not when she/he actually receives it.

If a benefit plan gives discretion to an administrator or a fiduciary who is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion. *Woo v. Hartford Life Insurance Company*, 144 F.3d. 1157 (1998). As in *Woo*, where there is a financial conflict, with the failure of the insurer to use proper judgment that is considered to be egregious conduct. If this is shown, these Circuits typically apply a sliding scale based upon the severity of the conflict.

In the Third Circuit, the rule is explained as "Although the fact that the decision-maker was also the insurer of the plan may not in itself warrant application of the least deferential standard of review, a 'high degree of skepticism' is necessitated in the presence of other extrinsic evidence of bias, such as procedural irregularities or inconsistent treatment of factual information." *Weinberger v. Reliance Standard Life Insurance Company*, 54 Fed. Appx. 553; (2002, U.S. App.) (internal citations omitted.) In other words, the Petitioner would have been held to a much lower standard in order to achieve a more deferential review of her claim, had she been able to file her complaint there, rather than in the Eighth Circuit.

There are other approaches adopted by the Circuits in determining the correct standard of review for these claims. The holdings of the Ninth and Eleventh Circuits state that once the Petitioner has proved a conflict of interest, the burden shifts. The Respondent must then prove that the conflict of interest did not effect the final decision of the Plan Administrator. The case of *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, (1995 U.S. App.) contains an excellent discussion of the various methodologies of the Circuits.

> "The Fourth Circuit states that where a substantial conflict is shown it 'will review the merits of the interpretation to determine whether it is consistent with an exercise of discretion by a fiduciary acting free of the interests that conflict with those of the benefits.' *Doe v. Group Hospitalization & Medical Serv.*, 3 F.3d 80, 87 (4th Cir. 1993); see also *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1952-54 (7th Cir. 1987) (describing 'sliding scale standard).
>
> The Eleventh Circuit takes a different approach; it has held that when a substantial conflict is shown, 'a wrong but apparently reasonable interpretation is arbitrary and capricious if it advances the conflicting interest of the fiduciary at the expenses of the affected beneficiary or beneficiaries unless the fiduciary justifies the interpretation...' *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1566 (11th Cir. 1990) (footnote omitted), cert. denied, 498 U.S. 1040, 112 L.Ed. 2d 701, 111 S.Ct. 712 (1991).

> Thus, there are at least two very different formulations of the standard. The Fourth and Seventh Circuits use a variable 'sliding scale,' always applying the abuse of discretion standard, but decreasing the deference given to a conflicted fiduciary's decision in proportion to the seriousness of the conflict. *Doe*, 3 F.3d at 87; *Van Boxel*, 836 F.2d at 1052-53. The Eleventh Circuit applies a two-tier standard, using traditional abuse of discretion review unless a 'serious conflict' is shown, at which point it will employ a more searching review. *Brown*, 898 F.2d at 1566."

*Id.* The interesting point to note, is that despite the significant difference of the various approaches adopted, these Circuits all take their guidance from the Supreme Court's holding in the case of *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 1001, 115, 103 L.Ed. 2d 80, 109 S.Ct. 948 (1989). "If a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed in determining whether there is an abuse of discretion." *Firestone Tire and Rubber v. Buch*, 489 U.S. 101,103 L.Ed.2d. 80, 109 S.Ct. 948 (1989). The Eleventh Circuit decided in the case of *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1566 (11th Cir. 1990) (footnote omitted), cert. denied, 498 U.S. 1040, 112 L.Ed. 2d 701, 111 S.Ct. 712 (1991) that following the Supreme Court's holding in *Firestone,* "the inherent conflict between the fiduciary role and the profit-making objective of an insurance company makes a highly deferential standard of review inappropriate. *Brown*, at 1562. A Ninth Circuit decision discussed their view of the Supreme Court's holding in the *Firestone* decision in the case of *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, (1995 U.S. App.):

> "In *Firestone*, the Supreme Court stated that 'if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion.' 489 U.S. at 115. Our own cases have interpreted this language to mean that we apply 'heightened scrutiny' where the plan administrator has a conflict of interest by virtue of its economic stake in the benefit decisions which it makes."

*Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, (1995 U.S. App.). The Second Circuit found that:

> "Following the standard of *Firestone* and *Pagan*, we conclude that, in cases where the plan administrator is shown to have a conflict of interest, the test for determining whether the administrator's interpretation of the plan is arbitrary and capricious is as follows: Two inquiries are pertinent. First, whether the determination made by the administrator is reasonable, in light of possible competing interpretations of the plan, second, whether the evidence shows that the administrator was in fact influenced by such conflict. If the court finds that the administrator was in fact influenced by the conflict of interest, the deference otherwise accorded the administrator's decision drops away and the court interprets the plan de novo."

*Sullivan v. LTV Aerospace and Defense Co.*, 82 F.3d 1251 (1996 U.S. App.). The holdings of the Ninth and Eleventh

Circuits seem to further the beneficent purpose of ERISA, as stated in 29 U.S.C.S. § 1001 "...that the continued well-being and security of millions of employees and their dependents are directly affected by these plans... that minimum standards be provided assuring the equitable character of such plans..." more so than the approaches taken by other circuits.

Further, many decisions rendered by individual circuits appear to be inconsistent with the general holdings in those circuits. Although the general rule in the Eighth Circuit is to apply the "sliding scale" once Petitioner has proven certain points, in the case of *Armstrong v. Etna Life Insurance Company*, 128 F.3d. 1263 (8th Cir. 1997), the Circuit Court held d*e novo* review of a Plan Administrator's decision is required in those cases which the Plan Administrator is also the insurer. Although that is the same factual situation as the instant case, Petitioner's suit in the same circuit was reviewed under the arbitrary and capricious standard. There is no consistency between the Circuits, and in some cases, within them, in deciding this issue.

## CONCLUSION

The Petitioner respectfully submits that in light of the conflicting standards of the circuit courts, and within the circuit courts, and their consistent recitation of a Supreme Court case in reaching these conflicting processes, that it is appropriate for this Court to determine which approach best serves the purpose and goals of ERISA, in order to grant all claimants a level playing field. Accordingly, Petitioner believes that this case warrants further review, and requests that a Writ of Certiorari be issued to review the decision of the Eighth Circuit Court of Appeals.

Respectfully submitted,

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## APPENDIX A

## UNITED STATES COURT OF APPEALS
## FOR THE EIGHTH CIRCUIT

**No. 02-2651**

**[Filed April 3, 2003]**

| | |
|---|---|
| Donna J. Farfalla, | ) |
| Appellant, | ) |
| | ) |
| v. | ) |
| | ) |
| Mutual of Omaha Insurance Company, | ) |
| Appellee. | ) |
| | ) |

Appeal from the United States District Court
for the District of Nebraska

**JUDGES:**
Before MORRIS SHEPPARD ARNOLD, BRIGHT, and SMITH, Circuit Judges.

## OPINION

MORRIS SHEPPARD ARNOLD, Circuit Judge.

This case involves a decision by the Mutual of Omaha Insurance Company (Mutual) to deny Donna Farfalla long-term disability benefits. Following a trial on Ms. Farfalla's action based on the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1101-1461, the district court[1] granted judgment in favor of Mutual. We affirm.

### I.

Mutual was the claims administrator for a long-term disability plan that Creighton University, Ms. Farfalla's former employer, provided to its employees. (Creighton was the plan administrator, but Mutual retained responsibility for investigating and deciding claims.) Where a disability plan gives an administrator "discretionary authority to determine eligibility for benefits," as the present plan does, a court usually reviews the administrator's decision for an abuse of discretion. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). A less deferential standard of review, however, is required when the claimant presents "material, probative evidence demonstrating that" there exists "a palpable conflict of interest" or "a serious procedural irregularity" that caused a "serious breach" of the administrator's fiduciary duty to the claimant. *See Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160 (8th Cir. 1998).

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[1] The Honorable Joseph F. Bataillon, United States District Judge for the District of Nebraska.

We agree with the district court's conclusion that an abuse-of-discretion standard is appropriate here, for although Mutual had a "palpable conflict of interest" because it served both as administrator and insurer of the plan (and no "ameliorating circumstances," as our case law terms them, exist), *see Schatz v. Mutual of Omaha Ins. Co.*, 220 F.3d 944, 948 (8th Cir. 2000) (internal quotations omitted), we do not believe that the conflict affected Mutual's determination. Less deferential review is warranted only when the conflict of interest or procedural irregularity "gives rise to serious doubts as to whether the result reached was the product of an arbitrary decision or the ... administrator's whim." *Id.* (internal quotations omitted).

The facts are undisputed. Under the plan, Ms. Farfalla was entitled to total disability benefits for twenty-four months if she was unable to perform the functions of her job. Thereafter, however, she became entitled to total disability benefits only if she could not "work for pay at any job for which [she was] reasonably fitted by education, training, or experience." When Ms. Farfalla fractured her wrist, which adversely affected her performance as a cardiac arrhythmia technician, she filed a claim for long-term disability benefits, which Mutual paid for two years.

During this two-year period, Ms. Farfalla suffered other injuries (and experienced complications from her first one), and Mutual continued to monitor her condition. An in-house reviewing physician noted his belief that she no longer qualified as totally disabled based on her job description, and recommended a functional capacity assessment (FCA). The FCA revealed that she had difficulty with such tasks as typing and manipulating small objects, but that she was able to work

at a medium physical capacity for occasional lifting and carrying. Dr. Jeffrey Tiedeman, Ms. Farfalla's treating physician, soon thereafter reviewed the FCA and released Ms. Farfalla for certain work. A few months later, she underwent surgery for carpal tunnel syndrome, after which Dr.Tiedeman again released her to return to work (with named restrictions). Despite job placement assistance from Mutual, Ms. Farfalla was unable to find employment.

At the end of the two-year period, Mutual terminated Ms. Farfalla's benefits. She appealed the decision and underwent two additional FCAs. These FCAs confirmed that she might have difficulty with certain tasks but noted that "she would be able to use the hands for gross manipulation" and could lift and carry certain items. Dr. Tiedeman reviewed the FCA and endorsed its recommendations as to the type of work that Ms. Farfalla could perform. Mutual then submitted the claim for medical peer review. The physician who performed the review concluded, based on Ms. Farfalla's records, that she "was able to perform some occupation as of January 1, 1997," but noted that "she may have some yet undiagnosed and untreated mental/nervous condition" that, though not rendering her "unable to work on that basis," might have contributed to her perception that she was disabled. Mutual then upheld its previous denial of benefits. Around a year and a half later, Ms. Farfalla was awarded social security disability benefits on account of fibromyalgia and related problems.

In our view, Mutual exhibited ample "reflection and judgment" before denying Ms. Farfalla's claim. *Cf. Clapp v. Citibank, N.A. Disability Plan (501)*, 262 F.3d 820, 828 (8th Cir. 2001). Mutual did not merely use an in-house medical

consultant to review Ms. Farfalla's claim; it sought independent review. Nothing in her records, her treating physician's opinion, or the FCAs ever indicated that she was unable to perform any job for which she was "reasonably fitted by education, training, or experience." *Cf. Heaser v. Toro Co.*, 247 F.3d 826, 833-34 (8th Cir. 2001).

Ms. Farfalla points to her later diagnosis of fibromyalgia and the fact that the peer review physician referred to an "undiagnosed and untreated mental/nervous condition," and argues that Mutual had an obligation to investigate further. We disagree. Even where a claimant is diagnosed with fibromyalgia before the administrator's final denial of benefits, the decision not to seek a specialist to review the total disability claim does not necessarily constitute a "serious breach" of the administrator's fiduciary duty. *See Clapp*, 262 F.3d at 827-28; *cf. Heaser*, 247 F.3d at 834. Given the steps that Mutual took to investigate Ms. Farfalla's claim here, we do not believe that further evaluation of her condition was required before denying her total disability benefits.

II.

We turn next to the question of whether the district court erred in upholding Mutual's decision. Mutual's determination is entitled to stand if it is supported by substantial evidence, *see Ferrari v. Teachers Ins. & Annuity Ass'n*, 278 F.3d 801, 807 (8th Cir. 2002), and in reviewing that determination we will "consider only the evidence that was before the administrator when the claim was denied." *Farley v. Arkansas Blue Cross & Blue Shield*, 147 F.3d 774, 777 (8th Cir. 1998).

Ms.Farfalla contends that the district court erred because,among other things, she suffered from numerous other medical difficulties besides her wrist injury, the purpose of the plan is to benefit disabled employees, and Ms. Farfalla was later deemed to be totally disabled by the Social Security Administration (SSA).

We disagree. First, there is no evidence anywhere in the record that Ms. Farfalla's condition met the definition of total disability that applied when her initial benefits were terminated, and there is considerable evidence to the contrary. *Cf. Heaser*, 247 F.3d at 834. Second, the purpose of the Plan is to benefit all covered employees, a purpose that is not furthered by paying an uncovered claim. *Cf. Tillery v. Hoffman Enclosures, Inc.*, 280 F.3d 1192, 1199-1200 (8th Cir. 2002). Third, an "ERISA plan administrator or fiduciary generally is not bound by an SSA determination that a plan participant is 'disabled,' " even when the plan's definition of disabled is similar to the definition the SSA applied. *See Jackson v. Metro. Life Ins. Co.*, 303 F.3d 884, 889 (8th Cir 2002). The onset date of Ms. Farfalla's SSA disability, moreover, was later than Mutual's reconsideration and denial of her claim. For these reasons and those expressed by the district court, we thus conclude that the district court did not err by entering judgment in favor of Mutual.

III.

Accordingly, we affirm the judgment of the district court.

## APPENDIX B

## UNITED STATES DISTRICT COURT
## FOR THE DISTRICT OF NEBRASKA

**No. 8:00CV630**

**[Filed May 21, 2002]**

DONNA J. FARFALLA,
Plaintiff,

vs.

MUTUAL OF OMAHA INSURANCE COMPANY,
Defendant.

**JUDGE:**
JOSEPH F. BATAILLON, United States District Judge.

### MEMORANDUM AND ORDER

This matter is before the court for decision after a trial on January 2, 2002. This is an action under the Employee Retirement Income Security Act (hereafter, ERISA), 29 U.S.C. § 1101, *et seq.*

## I. Findings of Fact

The facts of the case are undisputed. The administrative record that was before Mutual of Omaha Insurance Company (hereafter, Mutual) at the time it made its decision to terminate Farfalla's disability insurance has been offered and received into evidence. Exhibit 3. The record shows that Ms. Farfalla was employed as a cardiac arrythmia technician - shift leader at Creighton University (hereafter, Creighton) and was covered by a group long-term disability policy issued by Mutual to Creighton. Creighton purchased the policy to fund its long-term disability plan (hereafter, the Plan) for eligible employees. Creighton is the plan administrator and Mutual is the fiduciary responsible for investigating and deciding claims under the Plan. Pretrial Order, Filing No. 25, Undisputed Facts, ¶ B (4). The Plan gives Mutual "full authority and discretion to construe the terms" of the Plan. Exhibit 2 at FAR-19.

Under the terms of the Plan, Farfalla was entitled to disability benefits for twenty-four months if she was unable to perform the functions of her job. Pretrial Order, Filing No. 25, Undisputed Facts, ¶ B (8). At the end of twenty-four months, she became entitled to total disability benefits only if she could not "work for pay at any job for which [she was] reasonably fitted by education, training, or experience." *Id.*

On December 31, 1994, Farfalla fractured her wrist. The injury ultimately required two surgical procedures. Exhibit 3 at FAR-722. On February 1, 1995, she filed a claim for long-term disability benefits due to the injury. Pretrial Order, Filing No. 25, Undisputed Facts, ¶ B (6). After an

elimination period, Mutual began paying benefits to Farfalla beginning on January 30, 1995. *Id.* at ¶ B (7).

The medical records show that Farfalla continued to experience complications and pain from her injury throughout 1995 and 1996. Exhibit 3. Mutual obtained Farfalla's medical records and monitored her condition and continued paying benefits. *Id.* On October 16, 1995, an in-house reviewing physician noted "records reviewed and do not support [total disability] since at least 9-21-95 in my opinion based on job description," and recommended a Functional Capacity Assessment (hereafter, FCA). Exhibit 3, FAR-165-66. Farfalla underwent the assessment in November 1995. The report from the assessment indicates that Farfalla "remains limited in her tolerance to hand activities such as typing and manipulating small objects," but that she was able to work at a medium physical capacity level for occasional lifting and carrying, and at a heavy level for pushing and pulling.

On January 25, 1996, Farfalla's treating physician, Dr. Jeffrey Tiedeman, reviewed the FCA and released Farfalla to other work within its suggested guidelines, noting "she may have difficulty with constant operation of computer work station and frequent equipment operation." Exhibit 9 at FAR-100. He also suggested that a job site visit and specific recommendations by a physical therapist would be helpful. *Id.* In July 1996, after reviewing work analyses for Farfalla's prior jobs as both a "Monitor Tech" and a "Shift leader, Arrythmia Monitor Tech," Dr. Tiedeman released Farfalla to work as a shift leader, noting, with respect to the monitor tech position, that "my main concern is the occasional twisting of the wrist which is apparently required." Exhibit 10 at FAR-523.

In August 1996, however, Farfalla underwent surgery for carpal tunnel syndrome. Exhibit 11. On September 26, 1996, Dr. Tiedeman released Farfalla to return to work with the limitation that she could "gradually increase use of right hand over next two weeks; OK to seek employment, should not do data entry more than 50% of time at present." Exhibit 12. Mutual also provided Farfalla with job placement assistance during the time she was receiving benefits. Exhibit 3, FAR 522-25. The record shows Farfalla applied for several positions, but was unable to find employment. *Id.*

On December 31, 1996, Mutual notified Farfalla that it would terminate her benefits on January 30, 1997, because it had determined that she did not meet the Plan's definition of total disability. Pretrial Order, Filing No. 25, Undisputed Facts, ¶ B(9). Farfalla appealed that decision. Exhibit 22.

Farfalla underwent additional functional capacity assessments in February 1997 and in June 1997. Exhibits 25 and 28. The FCA performed in February 1997 found that Farfalla had "significant impairment of the hand which would preclude her from performing work requiring fine, rapid hand movements such as typing," but noted that "she would be able to use the hands for gross manipulation" and recommended limiting lifting to twenty pounds occasionally and ten pounds frequently. Exhibit 28 at FAR-317. The FCA performed in June 1997 included recommendations that Farfalla return to activities at or below levels of "minimal" for occasional hand grasping and fine manipulation, but did not otherwise impose substantial limitations on Farfalla's physical capacities. Exhibit 3 at FAR-375. Dr. Tiedeman reviewed the FCA and concluded "that the parameters outlined in the functional

capacity assessment be used as a guide for appropriate work restrictions." *Id.* at FAR-676.

Mutual's Medical Review Department again reviewed Farfalla's records and determined that the additional FCAs did "not support disability from any occupation." Exhibit 26 Mutual then submitted the claim to Disability Solutions Plus, Inc., for a medical peer review. Exhibit 31. The physician who performed the review concluded that "the claimant was able to perform some occupation as of January 1, 1997," but noted that "she may have some yet undiagnosed and untreated mental/nervous condition" that, though not rendering her "unable to work on that basis," "may be contributing to her present condition and how she perceives it." Exhibit 3 at FAR-621. In December 1997, Mutual denied Farfalla's appeal and upheld its previous denial of disability benefits. Exhibit 33.

Ms. Farfalla was later awarded Social Security disability benefits for a disability beginning on June 5, 1998, by reason of fibromyalgia. Exhibit 3 at FAR 576-581. Farfalla sought reconsideration of the appeal, submitting the Social Security decision in support of her position. Exhibits 36 and 38. Mutual declined to reconsider the decision. Exhibit 3 at FAR-572. Farfalla then filed this action.

**II. Discussion**

**A. Applicable Law**

**CONCLUSIONS OF LAW**

Under ERISA, a plan beneficiary has the right to judicial review of a benefits determination. *See* 29 U.S.C. § 1132(a)(1)(B). The first issue to consider in an ERISA case is the appropriate standard of review. *See, e.g., Tillery v. Hoffman Encls., Inc.*, 280 F.3d 1192, 1197 (8th Cir. 2002). Where a plan gives the administrator discretionary authority to determine eligibility for benefits, the court ordinarily reviews the administrator's decision for an abuse of discretion. *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160 (8th Cir. 1996). However, even if a plan gives the plan administrator discretion, a less-deferential "sliding-scale" standard of review is appropriate where a beneficiary presents material, probative evidence demonstrating that: 1) a palpable conflict of interest or serious procedural irregularity existed, 2) which caused a serious breach of the plan administrator's fiduciary duty to the claimant. *Morgan v. Contractors', Laborers, Teamsters, & Eng'rs Pension Plan*, 287 F.3d 716, 2002 WL 656049, *4 (8th Cir. 2002). A claimant must produce evidence sufficient to satisfy this two-point requirement in order for a court to apply the "sliding-scale" standard. 287 F.3d 716, *Id.* at *5. In so doing, the claimant offers evidence that gives rise to serious doubts as to whether the result reached was the product of an arbitrary decision or the plan administrator's whim. *Id.*

Farfalla has failed to meet that burden. She has not presented evidence that would warrant application of less

deferential review. *See, e.g., Ferrari v. Teachers Ins. & Annuity Ass'n*, 278 F.3d 801, 806 (8th Cir. 2002). Although Mutual's status as both insurer and administrator could be considered a conflict of interest, not every funding conflict compels that conclusion. *Tillery*, 280 F.3d at 1197. Farfalla has not produced evidence tending to show that the conflict, if any, caused a serious breach of the plan administrator's fiduciary duty. *See id.* at 1198.

Moreover, Farfalla can point to no procedural irregularities that are "'so egregious that the court has a total lack of faith in the integrity of the decision-making process'" from which to infer that the plan administrator did not use proper judgment. *Id.* The plan administrator did not merely use an in-house medical consultant to review plaintiff's claim; it sought review by an independent consultant. *Compare Woo*, 144 F.3d at 1161 (holding the "defendant failed to use proper judgment by not having a scleroderma expert review [the] claim"), *with Heaser v. Toro Co.*, 247 F.3d 826, 833-34 (8th Cir. 2001) (noting failure to provide a participant diagnosed with fibromyalgia with an examination by a doctor with expertise relating to her condition does not constitute a procedural irregularity that warrants application of the less deferential standard). Similarly, a mere failure to investigate a "host" of vague medical problems is not a procedural irregularity in the face of treating physicians' opinions that a claimant is not disabled. *See Clapp*, 262 F.3d 820, 827-28.

Accordingly, the court will apply the "abuse of discretion" or "arbitrary and capricious" standard of review. Under that standard, the court determines whether the plan administrator's decision to deny benefits was reasonable. *Clapp v. Citibank, N.A. Disability Plan*, 262 F.3d 820, 828

(8th Cir. 2001). To determine reasonableness, "the court must determine whether the decision is supported by substantial evidence, which is 'more than a scintilla but less than preponderance.'" Id. (*quoting Sahulka v. Lucent Techs., Inc.*, 206 F.3d 763, 767-68 (8th Cir. 2000)). A plan administrator's decision will be deemed reasonable if a reasonable person could have reached a similar decision, given the evidence before him. *Id.* Thus, the court will not disturb a decision supported by a reasonable explanation even though a different reasonable interpretation could have been made. *Id.*

Additionally, in conducting judicial review under the abuse of discretion standard, the reviewing court is limited to review of the evidence that was before the plan administrator when the final decision was made. *Oldenburger v. Central States S.E. and S.W. Areas Teamster Pension Fund*, 934 F.2d 171, 174 (8th Cir. 1991). Additional evidence may be considered by a district court in an ERISA benefit-denial case, however, if the plaintiff shows good cause for the district court to do so. *Ferrari*, 278 F.3d at 807. Farfalla has made no such showing. Under the circumstances, the court can consider only the evidence presented to Mutual before its denial of her appeal on December 18, 1997.[2]

Five factors are relevant to the determination of reasonableness: 1) whether the administrator's interpretation

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[2] Even if the court were to consider the evidence presented to Mutual later, the court would come to the same conclusion. The evidence presented to Mutual after the Social Security Administration had granted Farfalla's application for disability benefits did not establish that Farfalla was totally disabled at the time her benefits were terminated in January 1997.

is consistent with the goals of the plan; 2) whether the interpretation renders any language in the plan meaningless or internally inconsistent; 3) whether the administrator's interpretation conflicts with the substantive or procedural requirements of the ERISA statute; 4) whether the administrator has interpreted the relevant terms consistently; and 5) whether the interpretation is contrary to the clear langu:ge of the plan. *Finley v. Special Agents Mut. Ben. Ass'n*, 957 F.2d 617, 621 (8th Cir.1992).

The court's review of the evidence submitted to Mutual before its final decision shows that Mutual's decision was reasonable. The only conclusion that the administrative record supports is the conclusion that Farfalla was not totally disabled from "working for pay at any job" for which she was qualified. There is no evidence in the record that would support a contrary conclusion. Although there were intimations in the record, particularly in the February 1997 FCA, that Farfalla's condition was worsening, the evidence did not suggest any rapid deterioration or inability to function. Farfalla's own treating physician released her to return to work. The record shows that Mutual tracked plaintiff's medical history for two years and offered her job training. A determination that a claimant suffers from a disability under the Social Security regulations does not require an ERISA plan to reach the same conclusion. *Coker v. Metropolitan Life Ins. Co.*, 281 F.3d 793, 798 (8th Cir. 2002). ERISA plans are not bound by Social Security determinations, and this court owes no deference to findings made under the Social Security Act. *Id.*

The record demonstrates that Mutual's decision to deny benefits to the plaintiff was not unreasonable. The decision

comports with the purpose of a disability benefits plan. There has been no showing that Mutual's interpretation renders other plan language meaningless or inconsistent, or that the plan had been inconsistently applied. Farfalla does not contend that Mutual's denial did not comport with any substantive or procedural requirements of ERISA. The record amply demonstrates that Mutual's decision to deny total disability benefits to Farfalla was reasonable. The court finds Mutual is entitled to judgment in its favor on Farfalla's claim.

Accordingly,

IT IS HEREBY ORDERED that judgment is entered in favor of Mutual of Omaha.

Dated this 20th day of May, 2002.

BY THE COURT:

/s/_____
JOSEPH F. BATAILLON
United States District Judge

## APPENDIX C

## TRANSCRIPT EXCERPTS

[5]

Q. In fact, you had a hand or participated in deciding what benefits to pay under that policy issued to Creighton University, is that true?

A. I believe I became involved in the appeal of the claim.

Q. Okay, and I take it you are familiar with the policy that was issued to Creighton from Mutual of Omaha, is that true?

A. Yes.

Q. Mutual's role with respect to that insurance policy was that of a claims administrator, is that a fair statement?

A. Yes.

Q. And Mutual was also the party to decide what claims are to be paid, is that true?

A. Yes.

Q. And they are also listed as being the fiduciary, is that true?

A. Yes.

Q. You are aware of the fact that in that policy, as it was written, the fiduciary had a duty to act in the interest of the claimant, is that true?

A. Yes. To both parties, yes.

Q. In fact, there's language to that effect in the policy found in Exhibit 2, page 19, is that true?

A. I couldn't say for certain.

Q. Benefits paid pursuant to that policy are paid out of [6] Mutual's assets, isn't that true?

A. Yes, they would be.

Q. In other words, there was no trust set up by Mutual to fund disability payments, is that true?

A. Well, there is a reserve set up on all claims that are paid, yes.

Q. But those are monies that are under the control of Mutual of Omaha?

A. Yes.

Q. Not a third person or party, in other words?

A. Correct.

Q. And you are aware of efforts by Donna Farfalla back during that relevant period of time to seek employment, is that true?

A. Yes. There was an effort, yes.

Q. In fact, those efforts were unsuccessful, is that true?

A. At that time, yes.

Q. Benefits were paid out to Donna Farfalla under the terms of the disability policy up to January 30, 1997, true?

A. Yes.

Q. And at that time benefits stopped, is that true?

A. Yes.

Q. Do you happen to know or recall how much benefits were paid out?

A. Total benefits?

* * *

[10]

Q. Is it true that Mutual saved money by not having to pay disability payments to Donna Farfalla?

A. Yes, there would have been some savings, yes.

Q. So, therefore, Mutual's financial interest was affected by its decision whether or not to continue disability payments for Donna?

MR. WALDMAN: Objection, calls for a legal conclusion, and assuming facts that are -- foundation.

THE COURT: Overruled. The witness can answer.

THE WITNESS: I don't know that their financial interest would have changed that much with a denial of the claim. We assume a certain amount of claims.

BY MR. WRIGHT:

Q. Sure, but obviously it would have changed somewhat with one case and quite a bit more if you had hundreds of cases, true?

A. True, yes.

Q. Mutual considered her to be disabled and unable to perform her job until January 30, 1997, true?

A. I believe it was until December 31st of 1996, yes.

Q. Actually, it should have stopped December 31, 1996, but because she was involved with a plan of job placement they continued her for one more month, true?

A. Yes.

Q. Now, Mutual stopped paying Donna Farfalla disability

* * *

[17]

true?

A. Yes. If it was in his report, yes.

Q. I'm going to tell you exactly where it's located, Exhibit 3, page 622. But you do remember reading some language to that effect?

A. I remember there being a comment about there may be some psycho-social factors.

Q. The fact of the matter is, having reviewed her medical records you were aware of the fact that she was suffering from anxiety; isn't that true?

A. No, not at all.

Q. So if the medical records contain that type of information, you would not have reviewed that?

A. I don't recall any medical records, you know, making that comment.

Q. In making the decision to terminate her benefits did you review her medical record?

A. Yes.

Q. Who else besides you decided to terminate her benefits in

January of 1997?

A. It would have been the claims supervisor and a rehabilitation manager and most likely a nurse, registered nurse.

Q. You are aware of the fact, or Mutual of Omaha is aware of the fact that Donna Farfalla had in fact applied for

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(2)

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No. 03-55

In The

# Supreme Court of the United States

DONNA J. FARFALLA,

*Petitioner,*

vs.

MUTUAL OF OMAHA INSURANCE COMPANY,

*Respondent.*

**On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit**

## RESPONDENT'S BRIEF IN OPPOSITION

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## RULE 29.6 STATEMENT

Pursuant to Supreme Court Rule 29.6, respondent states that it has no parent companies and no publicly held company owns 10% or more of its stock.

TABLE OF CONTENTS


| | Page |
|---|---|
| RULE 29.6 STATEMENT | i |
| TABLE OF AUTHORITIES | iii |
| STATUTES AND RULES INVOLVED | 1 |
| STATEMENT OF THE CASE | 1 |
| A. The Plan | 1 |
| B. Petitioner's Claim For Long Term Disability Benefits | 2 |
| C. Termination of Benefits and Petitioner's Administrative Appeals | 4 |
| D. Petitioner's Post-Appeal Correspondence and Submission of Evidence | 5 |
| E. The Litigation | 6 |
| REASONS FOR DENYING THE PETITION | 8 |
| I. Petitioner's Claim Presents Poor Facts On Which To Clarify The Different Approaches Among The Circuits In Conflict Of Interest Cases | 9 |
| II. Petitioner Cannot Prevail Even Under A *De Novo* Standard Of Review | 13 |
| CONCLUSION | 15 |

# TABLE OF AUTHORITIES

Page

CASES

*Anderson v. Genuine Parts Co., Inc.*, 128 F.3d 1267 (8th Cir. 1997) ..... 13

*Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263 (8th Cir. 1997) ..... 10

*Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317 (9th Cir. 1995) ..... 12, 13

*Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556 (11th Cir. 1990) ..... 15

*Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) ..... 9, 13, 14

*Schatz v. Mutual of Omaha Ins. Co.*, 220 F.3d 944 (8th Cir. 2000) ..... 10

*Weinberger v. Reliance Standard Life Insurance Company*, 54 Fed. Appx. 553 (3rd Cir. 2002) ..... 11

*Woo v. Deluxe Corp.*, 144 F.3d 1157 (8th Cir. 1996) ... 6, 10, 13

STATUTES

29 U.S.C. § 1001 ..... 1

29 U.S.C. § 1132(a)(1)(B) ..... 1

OTHER AUTHORITIES

Note, *An Overview of the Inconsistency Among the Circuits Concerning the Conflict of Interest Analysis Applied in an ERISA Action with an Emphasis on the Eighth Circuit's Adoption of the Sliding Scale Analysis in Woo v. Deluxe Corporation*, 75 N.D. L. Rev. 815, 827-828 (1999) ..... 9

TABLE OF AUTHORITIES – Continued

Page

Restatement (Second) of Trusts § 187, Comment d (1959)..... 9

## STATUTES AND RULES INVOLVED

ERISA section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), provides in pertinent part as follows:

> (a) Persons empowered to bring a civil action
>
> A civil action may be brought –
>
> **(1)** by a participant or beneficiary –
>
> * * *
>
> **(B)** to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[.]
>
> * * *

## STATEMENT OF THE CASE

Petitioner Donna J. Farfalla brought this action under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*, seeking the continuation of the payment of disability benefits under a group long-term disability insurance policy. The policy was issued by respondent Mutual Of Omaha Insurance Company ("Mutual") to petitioner's former employer, Creighton University, to fund Creighton's Long-Term Disability Plan ("Plan"). (Joint Appendix 32 (hereinafter "Appx. ___").)

### A. The Plan

Creighton University is the Plan Administrator of the Plan. Mutual is the fiduciary responsible for investigating and deciding claims under the Plan. The Plan gives Mutual the authority and discretion to construe the terms

of the Plan and to decide all questions of eligibility under the Plan. (Appx. 32, 72.)

The terms "disability" and "disabled" are defined under the Plan as follows:

> **Disability and disabled** means your inability to work because of an injury or sickness. During your first 24 months of disability, you are totally disabled only if:
>
> (a) you cannot perform most of the main functions of your job; and
>
> (b) you are not paid for performing any other job.
>
> **After 24 months you are totally disabled if you cannot work for pay at any job for which you are reasonably fitted by education, training or experience.** (Appx. 33, 64) (emphasis added).

## B. Petitioner's Claim For Long Term Disability Benefits

In late December 1994, petitioner fractured her left wrist. Due to the fracture, she was unable to perform her job as a cardiac arrhythmia technician. She filed a claim for long term disability benefits under the Plan. Mutual accepted the claim and paid benefits to petitioner pursuant to the Plan for slightly over two years.

During the two year period, Mutual obtained petitioner's medical records and otherwise monitored her condition and progress, including her participation in vocational rehabilitation and job placement programs sponsored by Mutual. In October of 1995, an in-house

reviewing physician indicated that the records in the file "do not support [total disability] since at least 9-21-95 . . . based on job description." The reviewing physician further suggested that Mutual obtain a functional capacity assessment ("FCA") to determine petitioner's capabilities. (Appx. 128.)

Thereafter, Mutual arranged, through an outside vendor, for petitioner to undergo an FCA. The FCA report indicated that petitioner is "able to work at a medium physical capacity level for occasional lifting and carrying" and is "able to work at a heavy physical capacity level for pushing and pulling." (Appx. 132, 133.) The FCA report also was provided to petitioner's treating physician, Dr. Jeffrey Tiedeman. On January 25, 1996, Dr. Tiedeman indicated that, although petitioner may have difficulty performing her prior job as an arrhythmia monitor technician, he would release her to pursue other work within the FCA guidelines. (Appx. 141.)

In addition to the fracture of her left wrist, petitioner suffered from carpal tunnel syndrome associated with her right hand. On August 29, 1996, petitioner underwent a surgical procedure known as a carpal tunnel release. (Appx. 143.) *On September 26, 1996, Dr. Tiedeman indicated that petitioner would be able to return to work as of that date*. Dr. Tiedeman included the following restrictions in connection with his release to work: "May gradually increase use of right hand over next 2 weeks; ok to seek employment, should not do data entry more than 50% of time at present." (Appx. 144.)

Despite job placement assistance from Mutual, petitioner was unable to find employment in late 1996 and early 1997. The vocational rehabilitation specialist hired

by Mutual to assist petitioner in finding work indicated in a report that she had discussed petitioner's status with Dr. Tiedeman on several occasions, and that – following the carpal tunnel surgery on her right hand – Dr. Tiedeman had "released her to the position of Cardiac Monitor Technician or any other position that she desired in the medical community." (Appx. 145-151 (quoted passage at Appx. 146)).

### C. Termination Of Benefits And Petitioner's Administrative Appeals

By letter dated December 31, 1996, Mutual notified petitioner that it had decided to terminate petitioner's long term disability benefits under the Plan as of January 30, 1997. The letter advised that Mutual had determined that Petitioner did not meet the Plan's definition of total disability after 24 months. (Appx. 33, 152-153.) No benefits were paid to petitioner under the Plan after January 30, 1997.

Petitioner appealed the termination of her benefits. Petitioner subsequently submitted two additional FCAs to Mutual for consideration during her appeal. Although the FCAs indicated that petitioner might have difficulty with certain tasks, the reports state petitioner was able to use her hands for certain functions. Neither FCA indicated that she was unable to work. Dr. Tiedeman reviewed the latter of the two FCAs and recommended "that the parameters outline[d] in the functional capacity assessment be used as a guide for appropriate work restrictions." Dr. Tiedeman did not, however, prohibit Petitioner from working. (Appx. 167.)

In late November 1997, after obtaining additional medical records relating to petitioner's conditions, Mutual submitted petitioner's claim for an outside medical peer review. The physician who performed the review concluded that petitioner was "able to perform some occupation as of January 1, 1997" and "can work presently." (Appx. 169.)[1] Mutual then upheld its previous decision that petitioner "is ineligible for disability benefits based on her work capability and the definition of disability."

### D. Petitioner's Post-Appeal Correspondence And Submission Of Evidence

Over two years after Mutual's final decision denying petitioner's appeal, petitioner submitted to Mutual a copy of a March 24, 1999 decision by the Social Security Administration ("SSA") which awarded social security benefits to petitioner due to fibromyalgia and other problems. In response, Mutual explained that petitioner had appealed "the termination of benefits in 1997 as provided under ERISA, the claim was further reviewed, and the decision terminating benefits was upheld." (Appx. 174.) Mutual explained that its prior decision was based upon the change in the policy definition of disability after 24 months. Because petitioner had not satisfied the definition of disability at that time, benefits had been terminated.

[1] Although the reviewing physician noted that "there are a number of psychosocial factors that make this claimant have a significant mental/nervous aspect to her condition," he emphasized that he is "not suggesting that there is any medical evidence that she is unable to work on that basis . . . " Again, the reviewing physician concluded that petitioner "was able to perform some occupation as of January 1, 1997" and that she "can work presently."

Finally, Mutual noted that the SSA decision clearly states that the SSA awarded benefits for a disability *beginning June 5, 1998*, well after Mutual's decision to terminate benefits under the Plan as of January 30, 1997. (Appx. 174.)[2]

## E. The Litigation

Following a bench trial, the district court issued a Memorandum and Order in which it held that Mutual's claims determination under the Plan was subject to the deferential abuse of discretion standard. The district court examined whether a less deferential "sliding-scale" standard of review should be applied pursuant to *Woo v. Deluxe Corp.*, 144 F.3d 1157 (8th Cir. 1996), but determined that while "Mutual's status as both insurer and administrator could be considered a conflict of interest," petitioner did not produce "evidence tending to show that the conflict, if any, caused a serious breach of the plan administrator's fiduciary duty." (Petition, Appendix B at 12a-13a.)[3]

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[2] Petitioner argues in her Petition that Mutual had a palpable conflict of interest because it had a "financial incentive to shift the cost of disability to taxpayers by placing them on social security disability benefits." (Petition at 10.) Petitioner then argues that the fact she "did not receive Social Security Disability benefits until after termination of her ERISA benefits is irrelevant given that the financial offset occurs when the recipient qualifies for Social Security Disability, not when she/he actually receives it." (*Id.*) This argument by petitioner is a red herring. Putting aside petitioner's erroneous assertion that Mutual has the ability to "place" anyone on social security benefits, any potential financial benefit to Mutual that might arise from a Social Security determination would occur only when Mutual is *paying* benefits to a claimant. No financial benefit would arise to Mutual when it denies or terminates benefits, as Mutual did in this case.

[3] Mutual disagrees with petitioner's characterization in her Statement of the Case of the trial testimony of Gary Suing, Mutual's

(Continued on following page)

The district court then applied the abuse of discretion standard of review to Mutual's claims determination, pursuant to which a court examines whether the claims administrator's denial of benefits was reasonable. In holding that Mutual's decision was reasonable, the district court determined that the only conclusion supported by the administrative record is that petitioner was not totally disabled under the terms of the Plan:

> The *only conclusion* that the administrative record supports is the conclusion that Farfalla was not totally disabled from 'working for pay at any job' for which she was qualified. There is *no evidence* in the record that would support a contrary conclusion. . . . Farfalla's own treating physician released her to return to work.

(*Id.* at 15a) (emphasis added).

The Eighth Circuit Court of Appeals unanimously affirmed the district court's judgment. The circuit court agreed with the district court's conclusion that an abuse of discretion standard is appropriate, finding that the "palpable conflict of interest" arising from Mutual's dual roles as claims administrator and insurer of the Plan did not affect Mutual's claims determination. (Petition, Appendix A at 3a.) Significantly, the circuit court concluded that

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Manager of Group Disability Claims. For example, petitioner asserts that Mr. Suing testified at trial "in his words" that "Mutual had a financial interest which was affected by whether or not to continue paying disability payments to [petitioner]." *See* Petition at 7. A review of the transcript of the trial reveals that Mr. Suing made no such statement. See Petition, Appendix C at 19a-20a.

"Mutual exhibited ample 'reflection and judgment' before denying Ms. Farfalla's claim." (*Id.* at 4a.) The court also found the evidence overwhelmingly supported Mutual's decision:

> Nothing in her records, her treating physician's opinion, or the FCAs ever indicated that she was unable to perform any job for which she was "reasonably fitted by education, training or experience."
>
> * * *
>
> [T]here is *no evidence anywhere in the record* that Ms. Farfalla's condition met the definition of total disability that applied when her initial benefits were terminated, and there is considerable evidence to the contrary.

(*Id.* at 5a, 6a) (emphasis added).

## REASONS FOR DENYING THE PETITION

This case does not warrant the Court's review. Although the circuit courts have developed different tests to determine the amount of discretion to give to a claims administrator operating under a conflict of interest, this litigation presents a poor medium for considering different approaches to the standard of review because the facts of this case are so one-sided. The courts below examined the administrative record before Mutual at the time it made its claims decision and determined that (1) petitioner has not shown that Mutual's dual status as insurer and claims administrator had an affect on the claims decision, and (2) there is no evidence in the administrative record to support petitioner's claim of disability under the Plan after

twenty-four months. Under these facts, petitioner would not prevail under any of the tests utilized by the courts of appeals in conflict of interest cases. Even under the *de novo* standard of review, petitioner could not prevail in this lawsuit. Because resolution of petitioner's claim in this lawsuit does not depend on which standard of review is applied, this case does not warrant the Court's review.

## I. Petitioner's Claim Presents Poor Facts On Which To Clarify The Different Approaches Among The Circuits In Conflict Of Interest Cases.

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court held that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* at 115 (quoting Restatement (Second) of Trusts § 187, Comment d (1959)). The courts of appeals have taken different approaches in applying this language from *Firestone* to determine the standard of review in situations in which a claims administrator is also the insurer of the plan or otherwise operates under a financial conflict of interest. *See* Note, *An Overview of the Inconsistency Among the Circuits Concerning the Conflict of Interest Analysis Applied in an ERISA Action with an Emphasis on the Eighth Circuit's Adoption of the Sliding Scale Analysis in Woo v. Deluxe Corporation*, 75 N.D. L. Rev. 815, 827-828 (1999).

In this case, Petitioner argued to the courts below that the Eighth Circuit's less deferential "sliding scale" standard of review should have been applied to review Mutual's determination of her benefits. Under the test

formulated by the Eighth Circuit, in order for a less deferential standard to apply, a plaintiff must present "material, probative evidence demonstrating that (1) a palpable conflict of interest . . . existed, which (2) caused a serious breach of the plan administrator's fiduciary duty to her." *Schatz v. Mutual of Omaha Ins. Co.*, 220 F.3d 944, 947 (8th Cir. 2000) (quoting *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160 (8th Cir. 1998)). "It is only after a claimant clears this initial 'two-part gateway requirement,' that [a court applies] the 'sliding scale approach' of determining just how much less deferential the nature of the plan administrator's conflict warrants [a court] being to the plan administrator's decision to deny benefits." *Schatz*, 220 F.3d at 947.[4]

The lower courts determined that petitioner produced no evidence tending to show that Mutual's dual status as insurer and claims administrator caused a serious breach of Mutual's fiduciary duty or otherwise affected Mutual's

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[4] In addition to urging the Eighth Circuit to apply the sliding scale analysis, Petitioner argued that "[*d*]*e novo* review of a Plan Administrator's decision is required in those cases which the Plan Administrator is also the insurer," citing *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263 (8th Cir. 1997). Petitioner asserts in her Petition that the *Armstrong* decision evidences a conflict within the Eighth Circuit. (Petition at 14.) The Eighth Circuit has explained, however, that the "kind of conflict and improper motive that provoked de novo review in *Armstrong*, where the claims reviewers themselves apparently received direct personal financial benefits for rejecting claims, is different in kind from the sort of background conflict created by the mere fact that the same company is both the plan administrator and the plan insurer." *Schatz*, 220 F.3d at 947 n. 5. In the instant case, Petitioner did not argue, and presented no evidence, that Mutual's claims reviewers received direct personal financial benefits for rejecting claims.

claims decision. Accordingly, a less deferential standard was not applied.

Despite the factual determinations made by the lower courts in this case, petitioner now argues that she would have fared better under one of the conflict of interest tests employed by one of the other circuits. An application of the facts of this case to the other tests cited by petitioner show that the ultimate result would be the same – Mutual's decision terminating benefits must be upheld. For example, petitioner quotes the following language from *Weinberger v. Reliance Standard Life Insurance Company*, 54 Fed. Appx. 553 (3rd Cir. 2002), to support her argument that Mutual's decision would have been entitled to a less deferential standard of review in the Third Circuit:

> Although the fact that the decision-maker was also the insurer of the plan may not in itself warrant application of the least deferential standard of review, [citation omitted], a "high degree of skepticism" is necessitated in the presence of other extrinsic evidence of bias, such as procedural irregularities or inconsistent treatment of factual information.

*Id.* at 556.[5] In citing the Third Circuit's test, petitioner ignores the requirement that "other extrinsic evidence of bias" is needed before the "high degree of skepticism" is

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[5] The *Weinberger* case was not selected for publication in the Federal Reporter and has been designated as "not precedential" pursuant to the Third Circuit's Internal Operating Procedure 5.3.

employed. In this case, the district and circuit courts have concluded that there is no extrinsic evidence of bias.[6]

Plaintiff also directs this Court to the "presumptively void" tests used by the Ninth and Eleventh Circuits. Once again, the application of those tests to the facts of this case show that the ultimate result would be the same for petitioner. In *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317 (9th Cir. 1995), the Ninth Circuit reviewed the competing tests and determined that it employs a "methodology similar to that of the Eleventh Circuit." *Id.* at 1322.

> The "less deferential" standard under which we review apparently conflicted fiduciaries has two steps. *First, we must determine whether the affected beneficiary has provided material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary.* If not, we apply our traditional abuse of discretion review. On the other hand, if the beneficiary *has* made the required showing, the principles of trust law require us to act very skeptically in deferring to the discretion of an administrator who appears to have committed a breach of fiduciary duty.

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[6] In fact, the district court stated that petitioner "can point to no procedural irregularities that are so egregious that the court has a total lack of faith in the integrity of the decision-making process from which to infer that the plan administrator did not use proper judgment." (Petition, Appendix B at 13a) (internal quotation marks omitted).

*Id.* at 1323 (emphasis added). The first step of the Ninth Circuit's test is comparable to the two prong *Woo* test employed by the Eighth Circuit in the instant case. Since the courts below have determined that petitioner produced no evidence tending to show that Mutual's dual status as insurer and claims administrator caused a serious breach of Mutual's fiduciary duty or otherwise affected Mutual's claims decision, it is apparent that the outcome of petitioner's case would not change under the Ninth Circuit test.

Based upon the facts of this case, any differences in the courts of appeals' formulations of the standard of review would not result in a different outcome for petitioner. Accordingly, review of this case by this Court is unnecessary.[7]

## II. Petitioner Cannot Prevail Even Under A *De Novo* Standard Of Review.

In *Firestone*, this Court held that a denial of benefits under ERISA is reviewed *de novo* "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to

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[7] Mutual also notes that the final Pretrial Order entered in this case, and signed by Petitioner's attorney, clearly states that the issue to be decided by the trial court was "[w]hether Mutual of Omaha's decision to terminate Plaintiff's monthly long term disability benefits was arbitrary and capricious." *See* Order on Final Pretrial Conference ¶ (C) 1 (Appx. 33). It is well-established in the Eighth Circuit that the Pretrial Order governs the subsequent course of action in a lawsuit. *Anderson v. Genuine Parts Co., Inc.*, 128 F.3d 1267, 1271 (8th Cir. 1997). If the *Anderson* decision is followed, then petitioner has waived her right to argue for a less deferential standard of review.

construe the terms of the plan." 489 U.S. at 115. In addition, "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a facto[r] in determining whether there is an abuse of discretion." *Id.* (internal quotation marks omitted). In the case at issue, it is undisputed that the Plan gives Mutual discretionary authority to determine eligibility for benefits, and the courts below considered Mutual's dual status in determining that Mutual did not abuse its discretion.

Even if petitioner could convince this Court that Mutual's claims decision should be reviewed under the *de novo* standard, the result of this case would not change. The district court determined that "[t]he only conclusion that the administrative record supports is the conclusion that [petitioner] was not totally disabled from 'work[ing] for pay at any job' for which she was qualified." (Petition, Appendix B at Appx. 188.) Likewise, the circuit court stated that "there is no evidence anywhere in the record that [petitioner's] condition met the definition of total disability that applied when her initial benefits were terminated, and there is considerable evidence to the contrary." (Opinion of the Eighth Circuit Court of Appeals, Petition, Appendix A at 6a.)

Since the courts below determined that there was only one conclusion to be drawn from the administrative record, it follows that *de novo* review would not have altered the outcome of this case. As the Eleventh Circuit has recognized, it "is fundamental that the fiduciary's interpretation must be 'wrong' from the perspective of de novo review before a reviewing court is concerned with the self-interest

of the fiduciary." *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1566 n. 12 (11th Cir. 1990) (applying the "presumptively void" test).

Because the courts below determined that Mutual reached the only conclusion possible, this Court need not accept this case to review the question presented by petitioner. Consideration of that question simply would not change the outcome of petitioner's lawsuit.

## CONCLUSION

For all the foregoing reasons, the Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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